



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

STATEMENT OF LOSS/REPLACEMENT REQUEST

INSTRUCTIONS: Use this form to report food purchased with food stamp benefits destroyed in a household misfortune.

IDENTIFICATION

1. NAME		2. PAY COUNTY	3. DCN
4. SOCIAL SECURITY NUMBER	5. DATE OF BIRTH	6. LOAD NUMBER	7. SCN
8. CURRENT ADDRESS (STREET OR APT. NO.)		9. CITY, STATE, ZIP CODE	
10. PAYHIST ISSUANCE INFORMATION		11. DATE CLIENT REPORTED LOSS	12. DATE IM-110 COMPLETED
MO/YR	PAYROLL TYPE <input type="checkbox"/> REG <input type="checkbox"/> SUPP <input type="checkbox"/> EXP	ISSUANCE NO.	AMOUNT

REASON FOR LOSS

13. FOOD PURCHASED WITH FOOD STAMP BENEFITS IN THE AMOUNT OF \$ _____ WAS DESTROYED. VERIFIED BY COLLATERAL CONTACT OR COMMUNITY AGENCY.

14. DOCUMENTATION /DESCRIPTION OF LOSS (INCLUDE NAME OF COLLATERAL CONTACT OR COMMUNITY AGENCY)

TO THE HOUSEHOLD

If this statement is not signed and returned within ten days of the date the loss is reported, no replacement will be made.

SIGNATURE SECTION

I hereby certify, under penalty of perjury and/or fraud, that food purchased with food stamp benefits was destroyed as described above.

I understand that if I make fraudulent statements about food purchased with food stamp benefits being destroyed, I may be ineligible to continue in the Food Stamp Program and may be liable to prosecution under both Federal and State laws.

DATE	SIGNATURE
	▶
DATE	SIGNATURE (AGENCY)
	▶

FOR OFFICE USE ONLY

REPLACEMENT

15. <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED IF DENIED, WHY?		16. DATE
17. AMOUNT OF REPLACEMENT ISSUED BY COUNTY OFFICE \$	18. DATE REPLACEMENT ENTERED INTO SYSTEM	
19. NAME OF INDIVIDUAL ENTERING REPLACEMENT ISSUANCE IN SYSTEM ▶		